Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, including a requirement that competition to re-bid Round 1 occur in 2009. On January 16, 2009, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period that incorporates into regulations only those provisions of MIPPA related to the DMEPOS competitive bidding program that are self-implementing and necessary to conduct the Round 1 rebid competition in 2009. That rule became effective on April 18, 2009 and is available at *http://edocket.access.gpo.gov/2009/pdf/E9-863.pdf* on the Internet. It is crucial that DME suppliers be accredited in order to submit bids for the competitive bidding program. Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals/persons exempted from accreditation may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp* on the CMS website.

MLN Matters® Number: MM6511
Related Change Request (CR) #: 6511
Related CR Release Date: June 5, 2009
Effective Date: January 1, 2009 for implementation of fee schedule amounts for codes in effect then; April 1, 2009 for code K0739; July 1, 2009 for all other changes
Related CR Transmittal #: R1754CP
Implementation Date: July 6, 2009

July Quarterly Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6511 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for

implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is located in section 60, Chapter 23 of the Medicare Claims Processing Manual and is located at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS website. Other information on the fee schedule, including access to the DMEPOS fee schedules is at *http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp* on the CMS website.

Key Points of CR 6511

- The following table identifies the 2009 fees for the Healthcare Common Procedure Codes System (HCPCS) codes K0739/E1340. The * denotes revised for the 2009 fee schedule.

State	K0739/E1340	State	K0739/E1340
AK*	25.27	MT	13.41
AL*	13.41	NC	13.41
AR*	13.41	ND*	16.72
AZ*	16.59	NE	13.41
CA*	20.58	NH*	14.40
CO*	13.41	NJ*	18.10
CT*	22.40	NM*	13.41
DC*	13.41	NV*	21.37
DE*	24.71	NY*	24.71
FL*	13.41	OH*	13.41
GA*	13.41	OK	13.41
HI*	16.59	OR	13.41
IA*	13.41	PA*	14.40

State	K0739/E1340	State	K0739/E1340
ID*	13.41	PR	13.41
IL	13.41	RI*	15.99
IN	13.41	SC	13.41
KS	13.41	SD*	14.99
KY	13.41	TN	13.41
LA	13.41	TX	13.41
MA*	22.40	UT*	13.45
MD	13.41	VA	13.41
ME*	22.40	VI	13.41
MI	13.41	VT*	14.40
MN	13.41	WA*	21.37
MO	13.41	WI	13.41
MS	13.41	WV	13.41
		WY*	18.70

- The 2009 allowed payment amounts for codes E1340/K0739 are revised as part of this quarterly update to reflect updates that were brought to CMS' attention. The allowed payment amounts (listed above) for codes E1340/K0739 are effective as follows:
    - For claims with dates of service from January 1, 2009, through March 31, 2009 submitted using HCPCS code E1340 (Repair or Non-routine Service for DME Requiring the Skill of a Technician, Labor Component, Per 15 Minutes); and
    - For claims with dates of service from April 1, 2009, through December 31, 2009 submitted using code K0739 (Repair or Non-routine Service for DME Other Than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes).
- Medicare contractors will adjust previously processed claims for HCPCS code E1340/K0739 with dates of service on or after January 1, 2009 through June 30, 2009, if they are resubmitted as adjustments.
- HCPCS codes A6545, E0656, E0657 and L0113 were added to the HCPCS file effective January 1, 2009. The fee schedule amounts for these HCPCS codes are established as part of this update and are effective for claims with

dates of service on or after January 1, 2009. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for the above codes with dates of service on or after January 1, 2009 that have already been processed will not be adjusted** to reflect the newly established fees if they are resubmitted for adjustment.

- As part of this update CMS is adding the AW modifier to the fee schedule file for HCPCS code A6545 *Gradient Compression Wrap, Non-Elastic, Below Knee, 30-50 MM HG, Each.* Code A6545 is covered when it is used in the treatment of an open venous stasis ulcer. Currently, code A6545 is noncovered for the following conditions:
    - Venous insufficiency without stasis ulcers, prevention of stasis ulcers, prevention of the reoccurrence of stasis ulcers that have healed, and treatment of lymphedema in the absence of ulcers. In these situations, since an ulcer is not present, the gradient compression wraps do not meet the definition of a surgical dressing. **Suppliers are advised that when the non-elastic gradient compression wrap code A6545 is used in the treatment of an open venous stasis ulcer, it must be billed with the AW modifier.** Claims for code A6545 that do not meet the covered indications should be billed without the AW modifier and as such, will be denied as non-covered.
- As part of this update, the fee schedule amounts for HCPCS code K0606 (Automatic External Defibrillator, with Integrated Electrocardiogram Analysis, Garment Type) billed without the KF modifier are being removed from the DMEPOS fee schedule file.
- A one-time notification regarding the changes in payment for oxygen and oxygen equipment as a result of the MIPPA of 2008 and additional instructions regarding payment for DMEPOS was issued on December 23, 2008, (Transmittal 421, Change Request (CR) 6297). A related MLN Matters® article may be reviewed at *http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6297.pdf* on the CMS website). CR 6297 included 2009 labor payment rates for HCPCS codes E1340, L4205 and L7520.
- In 2009, code K0739 was established in the HCPCS file to replace code E1340 for Medicare claims for the repair of beneficiary-owned DME with dates of service on or after April 1, 2009 (see Transmittal 443, CR 6296 issued on February 13, 2009 which may be reviewed at *http://www.cms.hhs.gov/transmittals/downloads/R443OTN.pdf* on the CMS website). The 2009 allowed payment amounts for code E1340 mapped directly to code K0739.

Additional Information

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website. For complete details regarding this Change Request (CR) please see the official instruction (CR6511) issued to your Medicare MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1754CP.pdf* on the CMS website.